

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39348

State File No.

FILED DEC 9 - 1957

BIRTH NO.		REG. DIST. NO. <u>42</u>	PRIMARY REG. DIST. NO. <u>1000</u>	Registrar's No. <u>1319</u>
1. PLACE OF DEATH a. COUNTY <u>BUCHANAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>HOLT</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>MAITLAND</u>	d. Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. LENGTH OF STAY (in this place) <u>7 wks.</u>		e. STREET ADDRESS (If rural, give location) <u>7 mi. N.E. of Mound City</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Meth. Hosp.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>SHERMAN</u> c. (Last) <u>SMITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 27, 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>JUNE 22, 1879</u>	9. AGE (In years last birthday) <u>78</u>
10a. USUAL OCCUPATION (Give kind of work depending upon working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>GALLION, OHIO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William H. Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Ricker</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <u>HARRY LASELL, MAITLAND, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sarcoma Metastases</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Melanasarcoma, neck</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1957</u> , to <u>Nov. 27, 1957</u> , that I last saw the deceased alive on <u>Nov. 27, 1957</u> , and that death occurred at <u>10:10 pm.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Galen Sherman M.D.</u>		23b. ADDRESS <u>706 Francis St. Joseph, Mo.</u>		23c. DATE SIGNED <u>Nov. 29, '57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>11-30-1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SHILO E.U.B. Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>HOLT COUNTY, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-2-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Crawford</u> ADDRESS <u>Mound City, Mo.</u>

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed

James H. Crawford

Licensed Embalmer No. *4796*

P. O. Address *Mound City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.